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ABSTRACT

The skills-based method of remedial reading instruction is based on a medical model, in that it focuses instructional efforts solely on "curing" what is "wrong" with a reader. Such attention to students' shortcomings and the labeling of their lack of instant success as a problem causes healthy learners to begin to doubt their own abilities, often causing students who are progressing normally to fail. A case study of sixth grade students who had previously experienced reading failure and had been labeled handicapped, presumably because of this medical model of reading instruction, found that the students were disruptive and exhibited reading avoidance behavior. Their teacher replaced the medical model with an approach that provided the students with a genuine need to seek information by reading and with encouragement for work done rather than recognition of shortcomings. A design for success was arranged in a conference with each student, his or her parents, and the teacher in which goals and activities were planned. Students were expected to read what they could and attention was focused on what they had achieved. The students' self-concepts soon improved because they were more frequently and more productively involved in small group and whole class activities rather than working in isolation on specialized practice sheets to improve subskills. Behavioral changes attributed to this approach included reduced reading avoidance behavior and a genuine interest in reading for recreation. (Guidelines for using this approach in the classroom are included.) (HTH)

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IS THE MEDICAL MODEL MAKING OUR CHILDREN SICK—OF READING?

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IS THE MEDICAL MODEL MAKING OUR CHILDREN SICK--OF READING?

When you pay a visit to the medical doctor's office, the first question the doctor asks is: "What's wrong?" This quickly focuses the doctor's attention on the ailments and pains from which you are suffering and from which you are seeking relief. This model designed for the delivery of health care to individuals is based upon the notion that persons will consult the doctor when they are experiencing problems and the purpose of the visit will be to isolate the problem and seek a cure for it.

Several decades ago the education profession, for a variety of reasons, adopted a similar model as the model for teaching/learning in remedial classes. The model is now beginning to be used in regular classrooms as well (McGregor and Talbert, 1978). It seems to us that it is time that this decision be challenged--at least tested. There seems to us to be several serious flaws in the notion that the model is appropriate for all classroom reading experiences. The first and most obvious is that in the educational profession, most of our clients (i.e., students) are not ailing; they are healthy and normal learning human beings.

They make some mistakes but certainly they are not "educationally ill." To ask them what is wrong and to focus instructional efforts solely upon their shortcomings and to label their lack of instant success a problem causes healthy learners to begin to doubt their own abilities. Just as persons begin to experience symptoms of illness when they believe themselves to be physically ill, we believe

students sometimes fail to learn to read because they are constantly treated as if there is something wrong with them.

It seems to us that all children have some successes and some failures as they engage in the normal process of learning and that we should concentrate on the successes rather than going to great lengths to find problems to focus upon. Teachers should remember that most of the learners in their classes are educationally healthy; they are not ailing learners. Doctors see very few well patients, and teachers see very few ailing learners.

The Skills Model (alias--the Medical Model)

The skills-based approach to teaching reading (Kamm, 1978) attempts to divide the complex process of reading into smaller components, subskills, for the purpose of simplifying instruction. It is hoped that learning to read will be facilitated if the process is broken into smaller more manageable parts. These subskills are then arranged in a sequence with prerequisite skills being introduced and mastered before moving to other processes and to using them all as an integrated process. The main advantage of this approach, as seen by classroom teachers, is that instruction can be more precisely focused and managed. Being able to work with smaller more manageable units gives the teacher and the student the feeling that they can indeed master the total process. Teachers using this approach assume that the skills are generalizable and can thus be transferred to a variety of reading situations calling for those specific behaviors.

In general we agree with these elements of the model and also find these elements to be advantageous to the teacher of reading.

However, this approach, like virtually all other instructional models, teaches some things unintentionally. Unfortunately, two of the unintentional outcomes that are likely to result from the use of this model can easily overshadow the benefits. Since teachers regularly focus attention on the things the reader cannot do, learners can easily come to believe that they have reading problems and begin to approach future reading experiences with the expectation that they will fail when, in fact, they are making adequate progress. Because the model tends to focus an inordinant amount of attention upon the things the child fails to do or has difficulty in doing, the learner's successes seem to get lost, forgotten, or overlooked. Although we can agree, in general, with the basic elements of the model and find these elements to be advantageous to the teacher of reading, we question whether the benefits outweigh the problems.

What Happens When We Persist in Using the Model?

There is no doubt that schools and publishers now have a great deal invested in this model; decisions regarding classroom facilities, staff assignments, instructional aide time, and student materials have all been created with this model of instruction in mind. The issue we think must now be considered is: what happens to children when this model continues to be used inspite of the fact that it is not working?

The following describes one classroom teacher's observations of sixth grade students who had previously experienced reading failure for reasons which seem directly attributable to the use of the medical model and were because of it, labeled severely handicapped

readers, but yet the model was not challenged and instruction continued to be based on the children's failures. These observations were made over a period of ten years and included students from both upper-middle class homes and culturally deprived homes. They included students from broken homes, those who lived with both parents in well adjusted families, and students who lived with single parents.

Frequently classroom teachers hear and believe the "mythological" idea that some children learn inspite of how they are taught. However, what they fail to see is the price children pay for this kind of learning, a poor self image. For this reason we present this summary of the cases of five students that were placed in the sixth grade even though they had severe reading disabilities.

This summary is presented in order to illustrate that the medical model is frequently employed even though it seems to be achieving very little and when it is discontinued and replaced with a more success-oriented approach students can progress in the development of reading skills. The case study was used as the method of research instead of the typical comparison group method because use of the comparison group method always leads to a situation commonly called a "catch 22." Because that method relies upon test data for measuring progress, because you must break the reading process down into subskills to test the child, and because giving a test makes the child feel failure, the results are always contaminated. Thus it contains, inherently, the specific flaws that this article intends to expose

and replace with the idea that children can succeed at reading tasks which are part of a larger task which they want to complete even though they regularly fail when trying subcomponents of the "whole" process in a "test" situation.

Although these students entered in different years and there is a span of seven years in their present chronological ages, it can be noted that they entered the sixth grade with the following commonalities.

1. The basal reading approach was employed for beginning reading instruction.

2. Periodic diagnostic and achievement testing indicated that the students were failing to master the initial phonic and other word attack skills deemed necessary to achieve success in reading.

3. After evaluation data were processed, deficiencies were identified and prescriptive remediation was attempted. The records indicate that the same method of instruction, one in which the students had previously failed, was repeated.

4. Continued failure to learn how to read was the students' only consistent reading experience.

5. Further diagnostic testing identified specific reading deficiencies in vocabulary and comprehension development.

6. Eventually the students were grouped with others who were experiencing the same reading failures. These reading groups were smaller and allowed the students to receive more individualized instruction.

7. By the end of the second grade they were identified as handicapped readers and recommended for one-to-one instruction in a remedial

reading clinic or were placed in the multi-categorical resource rooms for prescriptive individualized instruction.

Two of the five students were in the reading clinic for a fifty minute period daily and in the resource room two hours daily. This schedule allowed them to participate in the regular classroom only two and one-half hours daily.

8. Cumulative records indicate a consistent declining interest in reading to learn.

9. Disruptive classroom behavior increased as these students failed to make worthwhile contributions when working in small groups in science and social studies.

10. At the time they were placed in the sixth grade they were reluctant learners with a "disabled reader" label. They were well known by all resource staff members, guidance personnel, and peers.

These students had developed a variety of behavior patterns over the years which demonstrated the degree to which their self esteem had fallen. Their behaviors also manifested the defense and avoidance strategies they had acquired during those years of failure. The following behaviors were used to manipulate teachers and to stall learning.

1. Aggressive refusal to participate in any activity which singled them out to work alone with the teacher or an aide. This behavior was usually demonstrated by verbally challenging the teacher and by refusing to cooperate.

2. Students mentally withdrew from group participation and failed to produce. When placed in teacher or peer groupings which were of a

one-on-one nature the students remained silent or said, "I can't."

3. Off-task behavior was commonly used. In this strategy the student tried to give the appearance of following directions with understanding but was soon off task and traveling to the pencil sharpener, restroom, water fountain, or even to the library.

A Strategy for Change When the Medical Model Fails

Admittedly when a student reaches the sixth grade and has learned how to avoid learning to read, drastic changes must be made. In an effort to find an instructional model that focused on what the children could read rather than upon what they couldn't read, the teacher discarded the medical model and began to search for a different way to work with the children's reading needs and abilities. The major change involved a change in focus; in the new strategy attention was focused on the information that could be learned by reading rather than upon the student's reading difficulties. An attempt was made to put the new model into practice during the students' sixth grade year.

The new strategy was based upon the contention that if given a chance, in the regular classroom, to use reading as one of several ways to seek information needed, the children would devise some of their own means to survive, i.e., to read. The regular classroom activities were designed so that there was (1) a genuine need for information, (2) an acceptance of responsibility by the students for sharing in the search, and (3) encouragement for the work done (not just recognition of shortcomings). Although this strategy cannot, by any stretch of one's imagination be termed new because it has never

been thought of before, it can be termed new because it has not been frequently carried out under close observation.

The following is a summary of the things the teacher did in order to search for a new instructional model and to help the students change their perception of learning and reading in a normal classroom.

Shortly after the beginning of the school year the teacher planned two conferences. The first conference was with the student. This conference was designed to confront the student with a plan for success in sixth grade inspite of the repeated failure previously experienced. A second conference was conducted with the parents, and the student in order to plan the learning procedure for the year.

The teacher prepared an outline of general expectations for the sixth grade. These included classroom management, academic performance, social contributions, and social responsibilities. These expectations were discussed in detail and agreed upon by the student, parents, and teacher. Consequences of failure to perform were clearly stated and agreed upon. A simple graph of achievement and growth was drafted at this time to help demonstrate and record progress.

Attention was focused on the students' capabilities rather than on their disabilities. The teacher accepted what the student could read and applied this understanding of his abilities when assigning tasks in which reading was needed to learn. The students' self concepts were soon improved because they were more frequently and more productively involved in small group and whole-class activities rather than working in isolation on specialized practice sheets to improve reading subskills. Resource teachers were used to help the

students and their peers in the classroom. The students were isolated for individual instruction only when they realized that it would increase their achievement in classroom tasks. Tutorial help in reading was arranged to compliment and strengthen classroom participation; this was scheduled each day before school began in the morning.

Expectations focused on previous successes and performance levels were reasonably set but were regularly within normal achievement goals. Simple record keeping provided visual evidence of daily performance and growth. This eliminated the manipulative arguments and denials that students frequently resort to when problems occur. Each team member (teacher, student, and parents) was, however, required to demonstrate trust, patience, tolerance, and self-control regularly. When the students began to respond to this plan, positive behavior was noticed.

The major change that was the key to the new approach was the lack of any attempt to maintain the medical model in the development of reading skills. Instead the students were expected to read what they could and the same demand, that of doing some classroom reading for information, was made of these students as was made of students labeled readers. The attention was, however, focused on what they did read rather than on what they could not read.

Two specific types of reading were required in the class: recreational reading, a daily twenty-minute period when everyone read a book for pleasure, without teacher or peer assistance. The second type, research reading, was used to learn. It was used whenever students needed to find information or develop ideas. To the teacher's

amazement, the students who were disabled readers read too.

The following is a summary of behavioral changes that occurred within these students as the teacher worked with them in this manner.

1. During free reading the disabled readers came prepared with a book they could read. Their body movements changed from slouching postures to comfortable interested reading postures. Legs, hands, and arms were engaged in reading.

2. Students spent less time trying to hide behind the book and glancing over the top to see who might be watching them.

3. Students began sharing books with the teacher and their peers.

4. Students began to keep a list of new words that held a special appeal for them as they read.

5. During research reading projects the students: (1) learned to use reference material, (2) learned to use the card catalog, (3) learned to scan newspapers and magazines for related information, and (4) participated in classroom activities, such as writing reports, plays, and fairs. They participated knowing they would be able to make worthwhile contributions.

As the students neared the close of sixth grade the one subtle indication of attitudinal change the teacher learned to listen for was: "Do you know what I read this morning?"

Guidelines for Coping With the Medical Model

It seems highly unlikely that significant numbers of teachers could stray from the medical model even if they wanted to. Therefore, it seems appropriate for us to suggest some ways in which you can overcome some of the negative features of the model while still

emphasizing and retaining the good points.

1. Refuse to act as if everyone in your class has a reading problem--instead create a classroom atmosphere which regularly and purposely focuses on what the children can do. For example, when a child reads a selection and fails to remember all the facts it contains, concentrate on those facts he does remember and help him put them to use.

2. Group your class into small groups for purposes other than skill instruction. Regularly group them on some other basis such as: interest, content learning needs, friendships, or random selection.

3. Remember that reading is just one of the communication skills; help the children grow in all the communications skills. Take advantage of every possible opportunity to help children see the relationship that exists between reading and the various other communications activities in which they are already successfully participating.

4. Help children set realistic and achievable goals; some children who regularly experience failure purposely set their goals too high so that when they fail they can save face by suggesting that anyone would fail at a task so difficult (Robbins and Harway, 1977).

5. Don't tell children the task is easy when you know it will be difficult for them. They need to feel that they have accomplished something worthwhile and substantial with all the effort they have expended. Telling them it will be easy, when it turns out to be very difficult for them, gives them the impression that they must be stupid (Weiner, 1979).

6. Believe in your students; believe that they can succeed. You

are constantly sending non-verbal messages; make those messages say that you believe in them.

7. Don't accept test results as the best (or only) measure of a child's upper limit of reading ability, make your classroom one in which the child can, because he wants to, demonstrate his best reading effort while doing interesting classwork. This means doing less drill on isolated and meaningless subskills of reading and more work using reading as one of several ways to learn.

An Alternative Model

This account of one teacher's attempt to change the instructional model for students who had met with failure in reading for so many years leads to the question: What might have been done to prevent reading failure? The following alternative model is offered for your consideration. It seems that the experiences which lead to greatest success in beginning reading are those which parallel success in learning to speak (McDonnell). When young children begin to say their first words everyone about them acts as if they are overcome with joy and they focus much attention on the things the child can say. There is no thought whatsoever given to the many things he cannot say. Even more importantly, he certainly isn't treated as if he has special problems to be overcome or corrected. When imperfect speech is generated by the new talker, no one shows any signs of disapproval or demands that the child correct it immediately or quit talking. Therefore, in learning to read, as in learning to speak, we should, like the doting parent, concentrate on the things the child can do. Make them feel proud of each new reading accomplishment and

begin immediately to provide opportunities for the new reader to use his new capability.

Like the new speaker is surrounded with talk we should surround the beginning readers with reading. Within this kind of environment they will learn that reading fulfills an important role in the total communication effort needed in their lives. They will also learn what reading is; they will be hearing the language of books while seeing the reading act modeled for them. They will learn that just because they can't read everything doesn't mean they can't read.

When beginning speakers make their first real progress in learning to speak they aren't just trying to speak, they are trying to communicate. Therefore, it seems that in order to be successful in teaching children to read we should also focus on the content not just on the technicalities of reading. It follows, then, that our instructional efforts should be such that each child is engaged in learning and practicing the technicalities of reading only when the content is highly interesting and useful to him or her.

In summary when children who have been previously taught by the medical model are given a chance in a regular classroom setting to engage themselves in the "whole reading task," they can succeed at many of the tasks which require reading skills. This is exactly what happened to the students observed in this study. This success, in turn, gives children confidence to try additional reading tasks and to change their own reading behaviors. This seems to be true because children are able to function at a higher level of ability when engaged in a "whole" reading task than when engaged in drill on isolated and

meaningless subparts of the process.

In the teaching of reading, teacher enthusiasm and support is imperative. Teachers who think of their students as beautiful and hard-working are more successful in teaching their children to read (Zehm, 1975). However, enthusiasm for reading must extend beyond the reading period into other subject areas. Positive and optimistic feelings about students and their capabilities must permeate all student-teacher relationships that take place in the classroom. Children who are expected to succeed do!

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